

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008485

STATE FILE NUMBER

FILED MAR 23 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 268

300

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1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY Cameron OR TOWN 520 West 4th. st.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp.#2		d. STREET ADDRESS (If outside, give location) 10 mt.	
3. NAME OF DECEASED (Type or print) First JOHN Middle SAXTON Last HOUGHTON		4. DATE OF DEATH Month Mar. Day 11 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17 1883
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Jeab Houghton		13b. MOTHER'S MAIDEN NAME Mary Jane Fu gate	
14. NAME OF HUSBAND OR WIFE Pearl Houghton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records State Hosp.#2 St. Joseph M	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 416X	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Jan. 5, 1959		COUNTY Mar 11, 1959 STATE March 11, 1959	
21. I attended the deceased from 10:00 A.M. to Mar 11, 1959 and last saw her alive on March 11, 1959 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Mohammad Tahir M.D.		22b. ADDRESS State Hospital #2, St. Joseph	
22c. DATE SIGNED 3-11-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 13 1959	23c. NAME OF CEMETERY OR CREMATORY Kingston Cemetery	23d. LOCATION (City, town, or county) (State) Kingston Missouri
24. FUNERAL DIRECTOR Poland Funeral Home Cameron Mo		25. DATE RECD. BY LOCAL REG. Mar 13, 1959	
26. REGISTRAR'S SIGNATURE Mr. Clark Goodell			

All diseases in Part I must be causally related.

Dr. Mohammed Tahir

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.